STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represents the findings of the Health Resurvey and investigations of complaint numbers #57237 and #56930 in the above named facility. A revised copy of the deficiencies was sent to the facility on 6/14/12.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a census of 123 residents. The sample included 24 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment for the residents on 4 of 8 halls on 3 of 4 onsite days of the survey. Findings included: - On 6/4/12 at 9:00 AM, during the initial tour, observation revealed a urine odor noted in the rooms of the following residents: Resident #133, Resident #58, Resident #128, Resident #14, and Resident #41. On 6/6/12 at 2:05 PM, during the environmental tour, observation revealed the following: 1. Urine odor in the entry to the Arbor unit.	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

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BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 253	Continued From page 1 2. The privacy curtain in resident # 131's room had wrinkles, stains, and was stuck in the sprinkle on the ceiling. The closet door was not on the track and would not stay closed. The call light plate on the wall was loose. 3. The call light plate in resident # 165's room was loose. 4. The North dining room had rippled carpet. 5. The thresholds on the North unit were sticking up; the threshold on North A had a nail sticking out. 6. The North B wing Nurse's nook had frayed carpet. 7. The toilet in resident # 50's room had water standing behind the toilet and water stains behind the toilet. 8. Two dirty fans in the laundry. 9. The exhaust vent over the toilet in 400 hall spa room had lint/dirt buildup on it. On 6/6/12 at 2:10 PM, Maintenance staff KK verified the above housekeeping/maintenance concerns. The facility failed to provide maintenance and housekeeping services to maintain a sanitary and comfortable facility.	F 253		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

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F 279	Continued From page 2 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility had a census of 123 residents. The sample included 24 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for 4 sampled residents: Resident #85 with edema and weight loss. Resident #1 who received Hospice care. Resident #128 for restorative care. Resident #8 for prevention of falls. Findings included: - Resident #85's admission (MDS) Minimum Data Set 3.0 assessment, dated 4-13-2012,	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 279	Continued From page 3	F 279		

revealed a (BIMS) Brief Interview for Mental Score of 3, severe cognitive impairment. It also revealed the resident required supervision with set up, assistance with eating, and did not have any swallowing, chewing, or other dental problems. The MDS revealed the resident did not have a significant weight loss or gain and received a therapeutic diet.

Review of the (CAAs) Care Area Assessment summary, dated 4-17-2012, revealed Nutritional Status triggered for further assessment and included the information the resident was on a therapeutic diet as recommended, able to feed him/herself, and make his/her food choices.

The weight book revealed the resident lost 23.4 pounds from 4/24/12 to 6/4/12.

The physician's fax communication, dated 4-13-2012, revealed the resident had 4 + pitting edema to bilateral extremities, left leg weeping and new orders for Lasix 80 milligrams (mg) daily and Vaseline gauze wrap treatment ordered.

Review of the Registered Dietitian notes, dated 4-18-2012, revealed documentation of edema with Lasix therapy, which may affect the resident's weight.

The care plan, dated 4/18/12, lacked interventions for weight loss and the use of the diuretics.

Observation on 6-6-12 at 4:23 PM, revealed the resident laid in bed wearing pants that exposed the resident's legs, which revealed the resident had no edema in his/her legs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 279	Continued From page 4 During an interview on 6-11-2012 at 4:21 PM, Administrative nurse I reported the facility had admitted the resident with 3+ pitting edema and the physician started the resident on high doses of Lasix. Nurse I verified he/she would expect to see the monitoring of weights, urinary output, edema, and lung sounds on the resident's care plan. The facility failed to develop a comprehensive care plan for resident #85 regarding weight loss and diuretic use. - Review of resident #1's significant change (MDS) Minimum Data Set 3.0 assessment, dated 3/27/12, revealed the resident had severe cognitive impairment, rarely/never understood and impaired decision making. No mood or behavior issues noted. The resident required extensive assist to total care of 1 to 2 staff for all daily cares. The resident was frequently incontinent, without skin breakdown and receiving Hospice care with a terminal diagnosis. The resident received pain medication on schedule and on an as needed basis with no symptoms of pain noted. The (CAAs) Care Area Assessment summary, dated 4/4/12, indicated the following: Cognitive CAA- The resident had several diagnoses which indicated reasons for cognitive loss. The resident had garbled speech, seldom understood, and needed help with all his/her(ADLs) Activities of Daily Living. ADL function/ rehab potential CAA- The resident had advanced dementia, absence of	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 279	Continued From page 5	F 279		

understandable language, long and short term memory deficits, and poor safety awareness. The resident needed skilled nursing care 24/7 and became a hospice client on 3/12/12 with the diagnosis of dementia.

Review of the care plan, dated 4/11/12, lacked any interventions related to hospice services and coordination of care between the facility and the hospice agency. The care plan also lacked any interventions addressing end of life care.

Review of the physician's orders, dated 3/21/12, revealed an order for the facility to admit the resident to Hospice for the diagnosis of failure to thrive.

Observation on 6/5/12 at 4:30 PM, revealed the resident in a wheelchair in the common area and no interaction with other residents in the area.

Observation on 6/6/12 at 8:40 AM, revealed the resident in bed on his/her back resting without signs of pain and his/her eyes closed. The resident had an alarm on the bed and the bed positioned in the low position.

During an interview on 6/6/12 at 7:30 AM, direct care staff E reported he/she was not sure what hospice did for the resident. Direct Care Staff E reported the facility staff provided all of the resident's care unless hospice called and wanted the staff to wait on the resident's bath. Staff E reported Hospice supplied the resident's briefs, gloves, and wipes, and when the supply started to run low, the staff would let the charge nurse know and he/she would call hospice to bring more supplies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 279	Continued From page 6 During an interview on 6/6/12 at 1:30 PM, Licensed Nurse F reported the facility was responsible for the resident and what care he/she received. The Hospice nurse would come to the nursing desk to get report of whatever was going on or any changes in the resident's condition before going to the residents room. The Home Health Aide from Hospice brought supplies for hygiene and the nurse would bring in treatment supplies. The facility failed to develop a comprehensive care plan which incorporated hospice services, coordinated the care the resident received, and failed to address end of life issues for Resident #1. - Resident # 128's admission (MDS) Minimum Data Set 3.0 assessment, dated 3/1/12, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 6, indicating the resident had severe cognitive impairment and had rejected care 4-6 days during the look-back period. The resident also required 1 person limited assistance for personal hygiene, bed mobility, transfers, and ambulation. Further indications included a risk for pressure ulcers and impaired range of motion to the resident's bilateral lower extremities. The CAAs, dated 3/6/12, indicated the resident had cognitive loss and needed staff assistance and reminders to manage his/her (ADLs) Activities of Daily Living. The CAAs further indicated the resident needed assistance for	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7	F 279		

mobility, transfers, locomotion, walking, toileting, and encouragement to eat and drink, and with bathing and grooming. The CAAs indicated the resident does not comprehend that he/she has limitations with performing his/her ADLs.

The care plan, dated 3/6/12, instructed the staff to encourage the resident to allow assistance with dressing, cares, changing incontinent pads, shaving and grooming. The care plan indicated the resident also received therapies to help gain his/her strength and endurance, and directed the use of adaptive equipment as needed. Review of the care plan revealed no interventions specifically addressing the resident's impaired range of motion to his/her lower extremities.

On 6/6/12 at 8:24 AM, observation revealed Nurse Assistant XX transferred the resident from the wheelchair to the bed using a gait belt and walker.

On 6/6/12 at 8:24 AM, Nursing Assistant XX verified the resident does have a therapy program in place if he/she will allow therapy to work with him/her.

On 6/6/12 at 4:45 PM, Administrative Staff TT stated that the care plans are done using a template but the staff attempts to individualize them based on the resident.

The facility failed to develop an individualized comprehensive care plan outlining the restorative services necessary for Resident #128, who had a limited range of motion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8	F 279		

- Resident # 8's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 2/23/12, indicated the resident cognitively intact with a (BIMS) Brief Interview of Mental Status score of 15. The MDS further indicated the resident required supervision with his/hers (ADL's) Activities of Daily Living.

The 5/24/12 care plan indicated the resident was independent with transfers and ambulation and directed the staff to assist the resident with transfers with a gait belt.

Review of the medical record revealed the resident had fallen on 5/30/12, 4/30/12 and 4/22/12 without sustaining any injuries.

Further review of the medical revealed a 3/2012 consultation with the psychologist recommending the staff post signs in the resident's room to remind him/her not to get up without calling for staff assistance.

The 5/31/12 Risk Management meeting related to the resident's fall on 5/30/12, revealed the resident was transferring himself/herself in the bathroom when the incident occurred. Staff encouraged the resident to wait for assistance before transferring.

On 6/15/12 at 2:03 PM, observation revealed the resident up independently, without staff assistance, in his/her wheelchair in the bathroom. The resident used the wheelchair to propel from the bathroom to the side of his/her bed in his/her room.

On 4 of 4 onsite days in the facility, observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 revealed the resident's room with no sign to remind him/her to call for help before getting up. On 6/6/12 at 4:53 PM, Nurse Assistant FF stated he/she knew that the resident was not to get up alone after he/she had his/her medications. On 6/6/12 at 4:15 PM, Nurse GG stated the staff were to be in the bathroom with the resident at all times. He/She further stated the staff had to consistently remind the resident of the need to call for help. On 6/6/12 at 1:59 PM, Nurse I verified the staff had not incorporated the March 2012 psychologist's recommendations into the resident's plan of care. Nurse I further verified the care plan had not been updated since his/her last fall on 5/30/12. The facility failed to develop a comprehensive care plan to direct the staff to provide appropriate care for the resident to prevent future falls for Resident # 8.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10	F 309		

The facility census totaled 123 with 24 residents included in the sample. Of those, 3 residents were reviewed for skin conditions other than pressure ulcers. Based on observation, interview and record review the facility failed to identify and assess possible causative factors for bruising for 1 of 3 residents. (#85)

Findings included:

- Resident #85's admission (MDS) Minimum Data Set 3.0 assessment,dated 4-13-2012, revealed a (BIMS) Brief Interview for Mental Status score of 3, severe cognitive impairment. The MDS also revealed the resident required extensive assistance of 1 staff person for bed mobility, transferring, toileting, and personal hygiene care, and indicated the resident did not have skin problems

Review of the pressure ulcer (CAAs) Care Area Assessment summary, dated 4-17-2012, revealed the resident was at risk for pressure ulcers and skin problems due to the resident's cognition problems, decreased mobility, and need for assistance for transfers and mobility. The summary revealed therapy provided strategies to increase the resident's strength and endurance, and the resident received prednisone,(a steroid medication) which could increase risk for skin breakdown.

The interium care plan, dated 4-10-12, revealed the resident had a potential for skin integrity problems with interventions that directed staff to provide long sleeves at night and during naps, and adjust the table heights in the dining room to prevent pinching or hitting of his/her hands and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11	F 309		

fingers.

Review of the care plan, dated 4-18-2012, revealed the resident had a potential for skin problems related to decreased mobility and cognition. The care plan directed staff to monitor skin during bathing and daily care, and directed the nurse to complete weekly skin assessments. The comprehensive care plan lacked evidence of implementations to prevent bruising.

Review of the nurse's notes, dated 4-7-12, revealed the resident did not have skin problems when admitted into the facility.

On 6-7-212 at 8:42 AM,observation revealed the staff assisted the resident down the hall and both of the resident's forearms had numerous bruises of multiple sizes from dime to quarter size with greenish to purplish colorations, and nothing covering his/her arms for protection.

Observation on 6-7-12 at 2:25 PM, revealed the resident sat on the side of the bed with his/her right arm against the bed rail. Further observation revealed a stool riser with hard plastic arm rests in the resident's bathroom.

During an interview 6-7-12 at 7:37 AM, Direct Care Staff Y reported he/she did not know about the current bruising on the resident's arms. Staff Y reported if he/she observed any bruising he/she would report it to the charge nurse. He/she also reported the resident had recently been getting up and down out of bed independently since he/she received physical and occupational therapy.

During an interview on 6-7-12 at 9:06 AM, Direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 Care Staff AA reported the resident needed limited assist with daily care needs and only trief to get up independently when he/she needed toileting. During an interview at 9:01 AM on 6-7-2012, Administrative Nurse L could not find the bath or weekly skin assessments except for one, dated 5-22-2012, that indicated the resident did not have any bruising. During an interview with Licensed Nurse Z on 6-7-2012 at 10:49 AM, he/she reported the bars in the bathroom could possibly be causing the bruising on the resident's arms. He/she also reported the nurse does investigations of bruises on all residents and then given to licensed staff L for review and then forwarded to Licensed Staff I. During an interview on 6-7-2012 at 2:21 PM, administrative licensed Nurse L did not remember seeing an investigation regarding bruising of resident #85's forearms and verified the monitoring of bruises was not on the treatment record for May, 2012. The facility failed to identify and assess possible causative factors placing the Resident #85 at risk for bruising on his/her forearms.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13	F 312		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 123 resident. The sample included 24 of which 3 were reviewed for Activities of Daily Living. Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain adequate personal hygiene for the prevention of urinary tract infections for 1 sampled resident. (#131)

Findings included:

- Resident #131's significant change (MDS) Minimum Data Set 3.0 assessment, dated 4/24/12, revealed the resident severely cognitively impaired, rarely made himself/herself understood, had severely impaired decision making ability, inattention, disorganized thinking and trouble concentrating. The resident required extensive assist of two with bed mobility,and total assistance of two staff with transfers dressing, and toileting.

Review of the (CAAs) Care Area Assessment summary, dated 4/26/12, revealed:

Cognitive CAA- The resident had advanced dementia and was no longer able to remember how to perform his/her (ADLs) Activities of Daily Living.

Activities of Daily Living
CAA- The resident had severe dementia. He/she had long and short term memory deficits, unable to express his/her needs or concerns, and dependent on others to meet his/her needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 14	F 312		

Review of the comprehensive care plan, dated 2/7/12, revealed the resident needed assistance with some of his/her daily tasks related to his/her dementia. The interventions included the resident required toileting assistance and directed staff to toilet this resident per his/her schedule listed on the cardex.

The cardex provided by administrative nurse A indicated the resident was incontinent of bowel and bladder and on a check and change every 2 hours toileting program.

Frequent observation on 6/5/12 from 2:10 PM to 5:00 PM, revealed staff did not provide incontinence care.

An observation on 6/6/12 at 7:05 AM, revealed the resident seated in his/her wheelchair in his/her room. The resident had clean clothes on and direct care staff J shaved the resident then handed the resident a toothbrush from the medicine cabinet with toothpaste on it. The resident put the brush in his/her mouth and made brushing movements. Staff J took the brush and completed the oral care.

Observation on 6/6/12 at 9:20 AM, revealed the resident wheeled to the back table in the commons area, while other residents had exercise class, the resident remained in the same position in his/her wheelchair with no care given to the resident by the staff.

Observation on 6/6/12 at 11:05 AM, revealed direct care staff C and J assisted the resident to his/her room. The staff transferred the resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 15	F 312		

his/her bed with the use of a mechanical lift and staff C and J put gloves on, took the resident's pants off, and proceeded to remove the resident's brief. During peri care, staff C reached into the container of wipes with contaminated gloves, gave them to staff J who then warmed them up with warm water while wearing the same soiled gloves. Direct care staff C only did peri care in the back and failed to clean the front genital area. Staff C and J put a clean brief under the resident but the brief tore while staff C tried to fasten it and staff C and J removed the brief. The resident urinated in the torn brief and when removed staff failed to do peri care at that time. Staff C and J put another brief on without providing pericare to the incontinent resident and pulled up the resident's pants. Direct care staff C and J, wearing the same soiled gloves, when licensed nurse F entered the room and wanted to apply cream on the resident's buttocks. Staff C and J then took the brief down and applied the cream, put the brief back on and transferred the resident to his/her wheelchair before removing their gloves.

During an interview on 6/6/12 at 12:30 PM, direct care staff C confirmed the (CNA) certified nurse aide cardex the aides carried in their pocket instructed the staff to check and change the resident every 2 hours.

During an interview on 6/5/12 at 2:50 PM, licensed nurse F confirmed that all CNAs had cardexes to care for the residents. Any changes with the resident went on the cardex.

During an interview on 6/6/12 at 1:00 PM, administrative nursing staff I confirmed that staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 16 should toilet and reposition and give the care the resident needed at least every 2 hours. The facility failed to provide the necessary services required to maintain good personal hygiene for Resident #131.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 123 residents. The sample included 24 residents of which 3 residents were reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to prevent the development of new pressure ulcers by the failure to accurately assess, monitor, and provide treatments to promote healing, including infection control measures, of pressure ulcers for 2 of 3 residents. (#174 and #17) Findings included: - Resident #174's admission (MDS) Minimum Data Set 3.0 assessment, dated 4-18-2012, revealed a (BIMS) Brief Interview for Mental	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17	F 314		

Status score of 15, cognitively intact. It also revealed the resident required extensive assistance of 2 persons for bed mobility and transfers, entered the facility with 1 or more stage one pressure ulcers and was at risk for developing pressure ulcers. The MDS indicated the resident had an unstageable suspected deep tissue wound, lacked documentation of a stage 1, 2, 3, or 4 ulcers as previously indicated and lacked any description of the tissue for the unstageable deep tissue ulcer. The MDS revealed staff provided turning and repositioning, ulcer care and the resident had a pressure reducing device on the bed.

Review of the Pressure ulcers (CAAs) Care Area Assessment summary related to the 4-18-2012 MDS revealed the resident had a decline in overall function due to a fall at home and subsequent hospitalization for pulmonary embolism that resulted in a decreased activity level and decreased appetite. It also revealed the staff planned to provide care for pressure ulcers as well as try to reduce occurrence of further skin issues. The CAA lacked any description, location, measurements of current pressure ulcer or preventative measures to prevent further pressure ulcers.

Review of the 14 day skilled assessment, dated 4-23-12, revealed 1 unstagable pressure ulcer with suspected deep tissue injury.

Review of the 30 day skilled assessment, dated 5-7-12, revealed 4 unstagable pressure ulcers with suspected deep tissue injury.

Review of the Braden scale risk assessment,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18	F 314		

dated 4-11-12, revealed a score of 15 which indicated the resident was at risk for developing pressure ulcers. The Braden scale risk assessment dated 5-1-12 revealed a score of 15 which indicated the resident was at risk for developing pressure ulcers with other factors including poor skin turgor, pain, and decreased mobility, nutrition and activity. Interventions included monitoring for pain, keeping skin clean and dry, physical and occupational therapy, and weekly skin review by the nurse.

Review of the care plan with a problem start date of 4-11-12 revealed a problem related to skin issues and decreased mobility. The goal was to have improvement in skin issues and directed staff to turn and reposition often, avoid sheering of skin during positioning, transferring and turning, conduct a systematic skin inspection weekly, keep clean and dry as possible, minimize skin exposure to moisture, and use pressure relieving boots when the resident was in his/her bed.

The care plan included the following updates:

An update on 5-23-2012 directed staff to administer doxycycline (an antibiotic) for 7 days for the wound on the resident's right heel. The note indicated the resident had an appointment for the wound clinic on 5-30-2012.

An update on 5-24-2012 directed the staff to cleanse the wound with wound cleanser, then apply hydrogel impregnated gauze, (a type of dressing), to the open area on the resident's right heel, and cover the area with a telfa and foam pad, (a type of dressing), and wrap.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 An update on 6-1-2012 indicated the resident needed to continue wearing the bilateral off-loading boots due to the pressure ulcer on the resident's right heel. It directed staff to apply Santyl, a type of medicated debriding ointment, to the resident's right heel, right medial foot pressure ulcer, and cover the areas with moist gauze, dry gauze, and foam dressing daily. It also directed staff to pad the red area on the resident's left lateral foot with foam and secure with tape for protection. Staff should do this treatment every 2-3 days and evaluate the resident's skin. Review of the wound assessment revealed the following pressure ulcer measurements: " Outside of left foot by left toe " (acquired after admission in facility) measurements included: 1. 4-26-2012 1.5 cm (centimeter) X 0.3 cm 2. 5-31-2012 it measured 1.6 cm X 0.7 cm an increase in size The inner right side of great toe, (acquired after admission in the facility) measurements included: 1. 4-26-2012 measured 1 cm X 0.5 cm 2. 5-31-2012 measured 0.5 cm x 0.3 cm 3. 6-6-12 measured 0.9 cm x 0.6 cm indicating an increase in size. The Daily Wound Assessment documentation revealed the resident developed a purplish blister on the right heel. 4-27-2012 - no measurements - purplish blister 4-28-12 - no measurements - brownish/purplish fluid filled soft and mushy 4-29-12 - no measurement - right heel area remains the same.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20	F 314		

Review of the current June 2012 treatment administration record revealed a pressure ulcer on the resident's right heel and directed staff to wear bilateral off-loading boots, apply Santyl (a type of debriding ointment) nickel thickness to right heel ulcer and right foot ulcer then cover with moist gauze, dry gauze and durofoam, a type of dressing and change every day. It also directed staff to wash right foot gently with soap and water and re apply santyl. For the left foot, it directed staff to pad the resident's left lateral foot reddened area with foam and apply tape protection - change every 2-3 days to evaluate the area. The treatment administration record directed staff to dress two pressure ulcers on the left foot, (back of heel and left outer foot) but the wound assessment documentation lacked any measurements of the ulcer on the back of the heel.

Review of the physician's progress note, dated 5-15-2012, revealed the resident was weak and not progressing well.

The physician's note, dated 6-5-12, failed to address the pressure ulcer on the resident's foot.

Observation on 6-5-12 at 2:12 PM, revealed the resident laid on his/her back with foam boots on both feet and the foot of the bed elevated.

Observation on 6-6-2012 at 7:43 AM, revealed licensed nurse P and licensed administrative nurse R prepared to complete the resident's dressing changes to his/her feet. After removal of the dressings to the right foot observation revealed an area on the inner right side of great

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21	F 314		

toe with a black center and approximately 0.5 cm (centimeters) of redness all the way around it. Administrative nurse R measured the blackened area which was 0.9 cm X 0.6 cm. The open area on the right heel had a yellowish hard center which administrative nurse R measured as 1.2 cm X 0.6 cm. Licensed nurse P then washed the resident's right foot and applied Santyl ointment and a dressing to each pressure ulcer without changing the soiled gloves between dressing changes.

Additional observations on 6-6-12 at 7:43 AM, revealed administrative nurse R removed the soiled dressings to the two areas on the resident's left foot. Without changing gloves administrative nurse R touched both wound beds with the soiled gloves. Observation of the pressure ulcer on the back of the resident's left heel revealed the ulcer had a black center and the entire heel appeared purple in color. The pressure ulcer on the outer part of the resident's left foot had a dried piece of skin covering part of the wound. Administrative nurse R washed his/her hands and applied a clean dressing without changing gloves between dressings.

During an interview on 6-5-2012 at 3:38 PM, direct care staff S reported the resident had sores on both heels and wore heel protectors on both feet. He/she also reported staff kept the residents legs elevated, checked at least every 2 hours on the resident to reposition him/her as well as monitor for signs of pain.

During an interview on 6-6-12 at 9:16 AM, direct care staff T reported the resident required extensive assistance of 2 staff for daily care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22	F 314		

wore foam boots on both of his/her feet to prevent pressure ulcers and the staff placed pillows under the resident's legs to keep his/her heels off the bed.

During an interview on 6-7-12 at 10:39 AM, licensed nurse P reported that when the resident admitted to the facility he/she was not in good physical shape. The resident's skin was very thin and in poor condition. He/she then confirmed the ulcers on the resident's feet were acquired after admission into the facility.

During an interview on 6-7-12 at 9:18 AM, administrative nurse I reported the the staff monitored the resident's skin at each bath time and nurse aides will look on the bath sheet with nurse to oversee it. The nurse needed to do one weekly skin assessment. Administrative nurse I reported that regarding pressure ulcers the nurses complete an initial daily assessment for 7 days and there is a wound log -that is used for quality assurance and improvement purposes. He/she reported the facility relied on the MDS coordinators to be accurately assessing and documenting on the MDS and following the MDS manual guidelines.

Review of the facility policy for skin and wound management revealed under Procedure #3 qualified staff will assess all residents weekly, from " head to toe " to identify any new pressure ulcers or other types of skin breakdown. A licensed nurse will document results of these assessments in the resident ' s medical record. Procedure #4 revealed that when a break in the skin is identified the licensed nurse would document a detailed assessment including type,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23	F 314		

size, stage, location, drainage, and odor of area. Documentation will also contain treatment orders obtained and a detailed personalized care plan.

The facility failed to provide pressure ulcer treatment using preventative infection control measures for Resident #174.

- Resident # 17's significant change (MDS) Minimum Data Set 3.0 assessment, dated, 4/23/12, revealed the resident rarely understands with a (BIMS) Brief Interview for Mental Status unable to be done. The MDS further revealed the resident was dependent on 2 staff for extensive ADL (Activities of Daily Living) assistance. The MDS revealed the resident had an impairment on both sides and was always incontinent of bowel and bladder. The MDS indicated the resident had a 6 month or less prognosis. The MDS further indicated the resident had an unstageable pressure ulcer with yellow slough measuring 1.2 (cm) centimeters long, 1.2 cm wide and 0.2 cm deep.

The 5/2/12 care plan directed staff to provide treatment to the resident's pressure ulcer as physician ordered. The care plan further directed staff to ensure offload pressure of the resident's heels with tubi socks to both feet, at all times.

Review of the certified nurse aide care plan did not reveal the instruction for staff to float the resident's heels.

The resident's wound progress notes revealed the following: dated 5/7/12 Right ankle, Stage 2 pressure ulcer measuring 2.0 (cm) centimeters long by 0.6 cm wide by 0 depth. Left Achilles,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24	F 314		

stage 2 pressure ulcer measured 0.9 cm long by 1.2 cm wide by 0.1 cm deep.

The resident's wound progress notes revealed the following: dated 5/14/12 Right ankle, Stage 2 pressure ulcer measuring 2.3 (cm) centimeters long by 0.6 cm wide by 0.1 depth. Left Achilles, stage 2 pressure ulcer measured 0.8 cm long by 1.2 cm wide by 0 depth.

The resident's wound progress notes revealed the following: dated 5/21/12 Right ankle, Stage 3 pressure ulcer measuring 2.5 (cm) centimeters long by 0.6 cm wide by 0.1 depth. Left Achilles, stage 2 pressure ulcer measured 0.7 cm long by 0.9 cm wide by 0 depth.

The resident's wound progress notes revealed the following: dated 5/29/12 Right ankle, Stage 3 pressure ulcer measuring 2.5 (cm) centimeters long by 0.5 cm wide by less than 0.1 in depth. Left Achilles, Stage 2 pressure ulcer measured 0.8 cm long by 0.8 cm wide by 0 depth.

The 5/7/12 nurse's note revealed, a certified nurse aide reported finding a scabbed area to the resident's right ankle area. Upon assessment, the wound measured 2 cm long by 0.6 cm wide by 0 depth and consistent with rubbing on the velcro closure on the foam boots.

On 6/5/12 at 4;22 PM, observation revealed the resident laid on the bed without his/her heels elevated.

On 6/6/12 at 9:30 AM, observation revealed the resident laid on the bed without his/her heels elevated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25	F 314		

On 6/6/12 at 1:53 PM, observation revealed the resident laid on the bed without his/her heels elevated.

On 6/6/12 at 3:45 PM, observation revealed the resident laid on the bed without his/her heels elevated.

On 6/7/12 at 7:15 AM, observation revealed the resident laid on the bed without his/her heels elevated.

On 6/7/12 at 9:00 AM, observation revealed the resident laid on the bed without his/her heels elevated.

On 6/7/12 at 10:38 AM, observation revealed Nurse Q and Nurse R at the resident's bedside for a dressing change. Hand hygiene performed and gloves applied. Nurse R removed the dressing from the resident's left Achilles and disposed of it. Observation of the wound revealed the area closed, red and staged at a Stage I. Nurse Q removed the dressing from the right ankle. Nurse Q then performed hand hygiene after disposing of the soiled dressing and applied clean gloves. Without performing hand hygiene Nurse R measured the wound on the resident's right ankle. The right ankle stage 3 pressure ulcer measured 1.8 (cm) centimeters long, 0.6 cm wide and 0 depth, yellow slough visible in the wound. Nurse R performed hand hygiene, applied clean gloves, cleansed the resident's right ankle wound with wound cleanser and patted dry. Nurse R used skin prep around the wound, applied silver dressing to the wound, covered with opti foam dressing, and wrapped the ankle with kerlix.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26	F 314		

Nurse R then applied a transparent dressing to the left Achilles wound.

On 6/6/12 at 7:34 AM, Nurse Assistant O revealed the resident did have foam boots to his/her feet but the boots were discontinued due to the straps rubbing his/her ankles.

On 6/7/12 at 9:00 AM, Nurse Q verified the resident was to have his/her heels floated at all times and verified the resident's heels were not being floated at the present time.

On 6/7/12 at 9:54 AM, Nurse Assistant LL stated the staff should elevate the resident's feet when he/she was in the chair.

On 6/7/12 at 9:00 AM, Restorative Staff MM verified that the resident's bed was not being used properly to float the resident's heels.

On 6/7/12 at 1:38 PM, Nurse I verified the staff had not used the bolster device to float the resident's heels. Nurse I further verified the staff may not be educated on the use of the bolster device for the bed.

On 6/7/12 at 1:40 PM, Nurse R verified the certified nurse aide care plan did not instruct the staff to float the resident's heels.

Review of the facility's undated policy, Process and Definitions of Wound Staging, revealed the following definition:

1) a Stage I pressure ulcer as an observable, pressure-related alteration of intact skin, whose indicators, as compared with the adjacent or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27 opposite area on the body, may include changes in skin temperature, tissue consistency and or sensation. 2) a Stage II pressure ulcer as a partial thickness skin loss involving the epidermis, dermis or both. The ulcer presents clinically as an abrasion, a blister or a shallow crater. 3) a Stage III pressure ulcer as full-thickness skin loss involving damage or necrosis of subcutaneous tissue, which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater, with or without undermining of adjacent tissue. 4) an unstagable pressure ulcer when accurate staging is not possible due to extensive necrotic tissue, slough and or eschar. Measurements and descriptions must be documented. The facility failed to float Resident # 17's heels as directed by the care plan. The facility also failed to provide necessary treatment and services to prevent Resident # 17 from the developing the facility acquired pressure ulcers.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 28	F 315		

function as possible.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 124 residents. The sample included 24 residents. Based on observation, interview, and record review, the facility failed to provide appropriated services to prevent urinary tract infections for 1 sampled resident. (#55)

Findings included:

- Resident #55's annual (MDS) Minimum Data Set 3.0 assessment, dated 5/17/12, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 11, indicated moderate cognitive impairment. The MDS further indicated the resident required extensive assistance with toileting and personal hygiene, and had a urinary indwelling foley catheter.

The 5/28/12 care plan directed the staff to keep the foley catheter dependent drainage bag in a drainage bag cover attached to bed or chair.

Review of the resident's medical record indicated the resident had a history of urinary tract infections.

On 6/5/12 at 4:00 PM, observation revealed the resident's indwelling foley catheter dependent drainage bag attached to the bed with no drainage bag cover.

On 6/6/12 at 8:19 AM, observation revealed Staff Nurse HH assisted the resident from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 29 wheelchair to his/her bed. Staff Nurse HH could not reach the catheter bag from under the wheelchair. He/She took it out of the protective cover and set it on the floor under the wheelchair during transfer. On 6/7/12 at 6:45 AM, observation revealed the resident sat on the side of his/her bed with the indwelling foley catheter drainage bag exiting from the resident's right pant leg. Observation revealed the catheter bag laid on the floor with no drainage cover bag over it. On 6/6/12 at 3:27 PM, Nurse Assistant II verified catheter bags should never be placed on the floor. On 6/6/12 at 4:10 PM, Nursing Staff JJ verified catheter bags should never be laid on the floor. Review of the Urinary Catheter and Drainage Bag Care policy, dated 10/1/09, indicated the following: #6. Do not allow the catheter bag holder, tubing, or spigot to touch the floor. The facility failed to provide appropriate services to prevent urinary tract infections for Resident # 55.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 30	F 318		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 123 residents. The sample included 24 residents. Based on observation, interview, and record review, the facility failed to provide services necessary to prevent a decrease in range of motion for 1 sampled resident.(#37).

Findings included;

- Resident #37's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 4-13-2012, revealed the resident no longer able to complete an interview to determine a (BIMS) Brief Interview for Mental Status score, experienced short term memory deficit. It also revealed the resident required extensive to total assistance from staff for daily care needs, received a restorative program for range of motion exercises, and had no limitation in range of motion to upper or lower body.

Review of the care plan dated, 4-12-2012, revealed it lacked guidance to staff on a restorative exercise program but directed nursing staff to provide range of motion exercises with care.

Review of the restorative progress notes revealed in February, March, April and May 2012 staff documented the resident wore a splint to his/her right hand between meals 5-7 times weekly.

Review of the Physician's Telephone order,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 31	F 318		

written 6-5-12, directed staff to put a splint on the resident's right hand in the morning and remove at hour of sleep for the resident's contractures.

Observation, on 6-5-12 at 2:21 PM, revealed the resident seated in a wheelchair in his/her room with his/her right hand under lap robe. Licensed staff BB started to enter the resident's room and assisted the resident in raising his/her right hand out from under the covers and the resident was not able to fully open his/her right hand. Staff BB reported the resident had a splint he/she needed to wear and went to the cabinet in the resident's room and got the splint that was sitting on top of it and put it on the resident. As staff BB applied the splint for the fingers the resident was very tight and still not able to straighten his/her fingers.

Observation, on 6-6-12 at 9:11 AM, revealed the resident seated in a wheel chair without a splint on -- Observation in the resident's room revealed a blue wrist/finger splint in the cabinet in the resident ' s room.

Observation, on 6-6-12 at 11:42 AM, revealed the resident's splint resting on the cabinet in the resident's room.

Observation, on 6-6-12 at 3:14 PM, revealed the resident again did not have the splint on as ordered by the physician. Observation revealed the splint remained on the cabinet in the resident's room wrapped together as previously observed.

Observation on 6-6-12 at 5:03 PM, revealed the resident seated at the dining room table without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 32	F 318		

wrists splint on his/her right wrist again.

Observation, on 6-7-12 at 9:21 AM, revealed direct care staff T and direct care staff VV provided perineal care and assisted the resident with getting dressed for the day. While providing morning care, the only range of motion provided by direct care staff T and W consisted of staff lifting and bending the resident's arms and legs while putting on his/her clothing. After staff completed assisting the resident with morning care staff W and T assisted the resident out of the room without applying the wrist splint, as ordered by the physicain.

Observation, on 6-7-2012 at 4:04 PM, revealed the resident without the blue splint on. Further observation revealed the splint lying on the cabinet in the resident's room. .

During an interview, on 6-5-2012 at 3:32 PM, direct care staff S reported the resident required total assistance of staff for daily care and did not wear any special type of devices, including splints or braces.

During an interview, on 6-7-2012 at 9:51 AM, licensed nurse P, when asked about the resident's hand splint, reported he/she had heard so many different things about when staff were to apply the splint and when to let the resident rest. Staff P also reported that sometimes he/she did not always get around to checking if staff applied the splint because he/she became busy helping staff provide care.

The facility failed to apply the hand splint and provide range of motion services to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 33 resident # 37 maintained his/her present range in motion and to prevent further decrease in range of motion.	F 318		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility had a census of 123 residents. The sample included 24 residents of which 3 were sampled for nutrition. Based on observation, interview, and record review, the facility failed to monitor body weight, identify weight loss, provide interventions in a timely manner to prevent significant weight loss, and to implement dietary recommendations for 1 of 3 sampled residents. (#131). Resident #131 experienced a significant weight loss of 24.6 pounds (10% in 6 months). Findings included: - Review of resident #131's significant change (MDS) Minimum Data Set 3.0 assessment, dated 4/24/12, revealed the resident was severely cognitively impaired, rarely made him/herself	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 34	F 325		

understood, had severe impaired decision making ability, inattention, disorganized thinking and trouble concentrating. The resident required extensive assistance of two with bed mobility, total assistance of two staff with transfers, dressing, toileting, and was non ambulatory and dependent on a wheel chair propelled by staff. The resident had a significant weight loss.

Review of the (CAAs) Care Area Assessment summary, dated 4/26/12, revealed: The Cognitive CAA revealed the resident had advanced dementia, was no longer able to remember how to perform his/her (ADLS) Activities of Daily Living, and depended on others to meet his/her needs. The Nutritional CAA-The resident fell and fractured his/her hip on October 17, 2011. The resident admitted to hospice on October 28, 2011. Currently his/her weight is stable although below ideal body weight range of 139-169 pounds. The resident was a Hospice client from 10/28/11 until 4/18/12. Indicated in the resident's weight history October, 2011, the resident weighed 152 (lbs) pounds and currently weighed 127.4 lbs.

During the review of the comprehensive care plan, with a revision date of 5/1/12, the facility failed to address the resident's nutritional status and weight loss.

The monthly weight sheet revealed the resident weighed 152 pounds on 10/2011,139 pounds on 12/4/12, 125 pounds on 3/4/12, 133 pounds on 5/4/12, and 131 pounds on 6/4/12.

Review of the dietary notes, dated 5/1/12, listed the resident's weight as 127.4 pounds. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 35	F 325		

resident received a regular diet with (CIB) Carnation Instant Breakfast twice daily. The dietary note revealed the residents eating ability, as needing assist with an intake of approximately 95-100%. The dietary note on the back of the sheet revealed the resident was no longer on Hospice services and received a regular diet. The dietary note revealed an 11% weight loss over the past 6 months with an increase of 2.3% over last 30 days. The plan was to continue to offer CIB, 2 times daily, monitor weekly weights, and continue to encourage intake, and foods and fluids of choice.

The clinical record lacked evidence of dietary interventions implemented consistently when this resident had consistent weight loss.

Review of the weight sheet with Administrative nursing staff A confirmed weekly weights were not done on the resident.

Review of the recommendations from the registered dietician for the period of May 2012 failed to address any issues with the resident's nutritional status, and confirmed by Administrative nursing staff A.

Review of the physician's order received on 5/24/12, revealed that a request to discontinue the CIB supplement, 3 times daily due to weight being stable. The resident was receiving CIB, 3 times daily, due to weight loss.

Meal service observation on 6/6/12 at 7:45 AM, revealed the resident was sitting at the dining room table with a 4 ounce glass of juice, and a 6 ounce glass of water. The resident was drinking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 36	F 325		

the juice by himself/herself. Observation revealed a bowl of fruit served to the resident and the resident picked up fork and began eating with no problems. The staff served plate with biscuits and gravy, scrambled eggs, and hot cereal. Observation revealed the resident feeding him/herself with supervision of the direct care staff sitting at the table. Review of the breakfast plate after the resident finished with the meal revealed that he/she ate approximately 50% of the eggs and a few bites of the sausage and gravy and drank both glasses of fluid. The resident did not eat the hot cereal.

Observation of the 2nd meal on 6/6/12 at 12:30 PM, revealed the resident with a dinner plate of a meat and noodle casserole, green beans, a roll and a bowl of fruit. The liquids included a glass each of juice and water. The resident seated at a table with his/her spouse for the noon meal.

Observation on 6/6/12 at 1:00 PM, revealed the resident ate 100% of the casserole, all but a few green beans and 1/2 of the roll. He/she also consumed all the offered fluids.

Observation on 6/7/12 at 9:00 AM, revealed the resident had eaten 2 pieces of French toast, bacon and a fruit bowl. He/She also consumed 8 ounces milk, and two glasses each of juice and water.

An interview done on 6/7/12 at 8:45 AM, revealed the direct care staff C reported they weigh all residents during the first few days of each month unless instructed to do it more frequently. When the staff weighs the residents, the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 37	F 325		

documents the weights on monthly weight sheets and gives to Administrative nursing staff. The administrative nurse reviews and monitors the weights and will let staff know which residents need re-weighed.

During an interview on 6/7/12 at 8:33 AM, dietary staff B revealed that he/she had ordered weekly weights, and confirmed the weights were not done. Dietary staff B revealed that he/she based his/her decision to discontinue the CIB based on the monthly weight showing the resident had gained 2.3%. Dietary staff B reported that changes are communicated during the weekly risk meeting with all department managers present.

During an interview on 6/7/12 at 8:10 AM, Administrative nursing staff A questioned if the resident had a significant weight loss. The Administrative nursing staff CC pulled the prior MDS showing the weight losses. The nurse reported he/she was just looking at the last couple of months of weights, not the 6 month window for significant loss.

During an interview on 6/7/12 at 3:00 PM, Administrative nursing staff I reported he/she was unaware of the resident's weight loss and would need to check with the nurses on the unit.

During an interview on 6/7/12 at 3:30 PM. Consultant EE returned the call and reported that the facility sends his/her a weight list once a month with weight loss flagged or they will notify him/her when he/she comes to the facility. He/She could not recall having any weight issues flagged for the resident in his/her recent visits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 38 Review of the Dietary Services Policy, dated 6/6/12, revealed the nursing staff notifies the Dietary Services Department in writing if a resident meets any of the following criteria: change in diets, weights with a loss/gain of 3% in one week, 5% or more in 30 day, 7.5% in 90 days 10% in 180 days. Decrease in appetite, abnormal labs, skin breakdown, new medication orders, or illness. The facility failed to provide interventions as planned.	F 325		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 39	F 353		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 123 residents. Based on observation, record review and interview, the facility failed to have adequate staffing to ensure the residents received necesssary care services to meet the residents needs.

The facility census totaled 123 with 24 residents included in the sample. Of those, 3 residents were reviewed for skin conditions other than pressure ulcers. Based on observation, interview and record review the facility failed to identify and assess possible causative factors for bruising for 1 of 3 residents. (#85)

The facility had a census of 123 resident. The sample included 24 of which 3 were reviewed for Activities of Daily Living. Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain adequate personal hygiene for the prevention of urinary tract infections for 1 sampled resident. (#131)

The facility had a census of 124 residents. The sample included 24 residents. Based on observation, interview, and record review, the facility failed to provide appropriated services to prevent urinary tract infections for 1 sampled resident. (#55)

The facility had a census of 123 residents. The sample included 24 residents. Based on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 40 observation, interview, and record review, the facility failed to provide services necessary to prevent a decrease in range of motion for 1 sampled resident.(#37). The facility had a census of 123 residents. The sample included 24 residents. Based on observation, interview, and record review, the facility failed to provide services necessary to prevent a decrease in range of motion for 1 sampled resident.(#37). Alert residents and families interviewed stated that the facility lacked adequate staff to meet their needs. Residents stated they have to wait a long time to get assistance. Families stated that staff do not provide care and services to toilet or repostion residents in a timely manner. The facility failed to provide the necesary care and services to meet the residents needs.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 41	F 371		

by:
The facility had a census of 123 residents. The sample included 24 residents. Based on observation, record review and interview the facility failed to prepare, distribute and serve food under sanitary conditions in 2 of 2 kitchens and 1 of 3 dining rooms on 4 of 4 days onsite of the survey.

Findings included:

- On 6/4/12 at 11:17 AM, observation in the south dining room revealed Nurse Assistant OO, handled glasses by the rim to distribute to the residents.

On 6/4/12 at 11:24 AM, observation in the south dining room revealed Nurse Assistant PP, handled glasses by the rim to distribute to the residents.

On 6/4/12 at 11:25 AM, observation in the south dining room revealed Nurse Assistant QQ, handled glasses by the rim to distribute to the residents.

On 4 of 4 onsite days in the facility, observations revealed multiple dietary staff members with hair not contained under a hairnet in 2 of 2 kitchen preparation areas.

On 6/6/12 at 11:30 AM, Dietary Staff B verified staff should distribute glasses to the resident's by the middle or the bottom of the glass. Dietary Staff B further verified that hair should be contained completely under the hairnet.

Review of the facility's policy dated 1/1/01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 42 indicated that hands were not to touch areas of utensils, dishware or silverware where the food or mouth will be placed. The policy further indicated anyone working in, visiting, or inspecting the kitchen during normal food production hours were expected to wear appropriate clothing, shoes, and hair covering. The facility failed to prepare, distribute and serve food under sanitary conditions for the residents.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 43 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: - Observation on 6-4-2012 at 9:04 AM revealed the following multi-dose vials of medication in the North medication room without an open date as follows: 1) Flulaval vial with approximately 3/4 vial remaining. 2) Flulaval vial with approximately 1/4 vial remaining. 3) Flulaval vial with an open date of 2-10-2012 on the box 4) Pneumococcal vaccine with an expiration date of May 2012 On 6-4-2012 at 9:04 AM, Licensed Nurse AAA confirmed staff had not dated the Flulaval vials and the Pneumococcal vaccine vial that had expired. During an interview on 6-12-12 at 10:00 AM, Administrative Nurse I reported he/she expected the nurse that opened the vial to put the date and their initials on it when opened. Review of the facility policy, dated 5/8/2002, for Medication Management Guidelines under Vials and Ampules of injectable medications #3 B. revealed "The date opened and the initials of the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 431	Continued From page 44	F 431		

first person to use the vial are recorded on multi-dose vials".

The facility failed to adequately monitor the usage of vial medications for expiration date and failed to follow facility policy on dating multi-dose vials.

The facility reported a census of 123 residents residing in the facility. Based on observation, interview, and record review, the facility failed to establish a system to ensure that expired and unlabeled medications were removed and disposed of after expiration.

Findings included:

Review of the website for Novolog insulin novolog.com/index.jsp revealed the Novolog flexpen should be discarded in 28 days if open or 28 days if not open and not refrigerated.

Review of the website for Levemir insulin www.novonordiskcare.com
revealed the Levemir insulin flexpen should be discarded after 42 days whether it is open or not and should not be refrigerated.

Review of the Aventis Pasteur printed information September 2001, on the Tubersol tuberculin test revealed that a vial of Tuberculin TTD, which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency.

-During initial tour on 6/4/12 at 9:30 AM, an observation of the locked medication cart on hall 3 revealed an unlabeled open cup containing 10 individual Vitamin E capsules. The medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 431	Continued From page 45 was confirmed by Nursing Staff N. Observation of the medication cabinet for an unsampled resident revealed, a Novolog flexpen with no open date and approximately 1/3 of insulin remaining. Also in the cabinet, a Levemir flexpen with no open date and very little insulin remained in the pen. During interview on 6/4/12 at 9:35 AM, licensed nurse P confirmed the pens were open and without open dates for an unsampled resident. Observation on 6/4/12 at 9:45 AM, revealed the medication cabinet of a second unsampled resident revealed an open Novolog flexpen with no open date and approximately 200 units, remained. A Levemir flexpen with no open date and approximately 1/2 used, found in the cabinet also. Observation on 6/4/12 at 9:50 AM, revealed the medication cabinet of a third unsampled resident revealed a flexpen with no open date with remaining insulin in the pen also a Levemir flexpen with no open date and remaining insulin in the pen. Observation on 6/4/12 at 9:55 AM, revealed the medication cabinet of a fourth unsampled resident revealed an open Levemir pen with remaining insulin in the pen with no open dates. During an interview on 6/4/12 at 9:55 AM, licensed nurse Q confirmed the pens were open with no open dates for three of the unsampled residents.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 46 Observation on 6/4/12 at 10:00 AM, of the medication refrigerator on 400-500 halls revealed an open vial of Tubersol (TB test) with no open date and approximately 3-4 doses remaining. During an interview on 6/4/12 at 10:00 AM Administrative nurse A confirmed the vials were open with no open dates. . During an interview on 6/12/12 at 10:00 AM, Administrative nurse I reported he/she expected the nurse who opened the medications to date them. The Policy Medication Management Guidelines dated 6/7/12 revealed: No discontinued, outdated or deteriorated drugs may be retained for use. Vials and ampules sent from the provider pharmacy in a box or container with the label on the outside are kept in that box or container. The date opened and the initials of the first person to use the vial are recorded on a multi-dose vial. No instructions for the use of insulin. The facility failed to establish a system to ensure that expired and unlabled medications were removed and disposed of after expiration.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility had a census of 123 residents with 24 included in the sample. Based on observation, interview, and record review, the facility failed to provide appropriate personal hygiene and infection control techniques for 2 of the 24 residents sampled and failed to create a standard	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48	F 441		

of cleaning and disinfecting for resident #103 with clostridium difficile, a type of infection.

Findings included:

- During an interview on 6-5-2012 at 2:06 PM, Housekeeping Staff U reported they used an all-purpose disinfectant, and toilet cleaners. He/she reported that if a resident had C-difficile, a type of infection, they had a special vinegar base cleaner that is used to clean everything in the room.

During an interview on 6-6-12 at 11:33 AM, Housekeeping Staff YY reported if a resident had C-difficile, there was a cart kept in the hall with isolation supplies, including gowns and shoe covers. He/she reported there was a special cleaner staff had to check out from the main housekeeping closet and they spray everything in the resident ' s room, let it set for about 5 minutes and then wipe dry and the soiled rags are placed in a yellow bag. He/she also reported staff do not use the special cleaner on the floor but everything else that may be touched by the resident or staff.

Housekeeping Staff V, on 6-6-12 at 12:13 PM, reported the facility used a product called VIRASEPT from Eco lab that on the manufacture use, stated it kills and/or inactivates C-difficile spores. Staff have a spray down list that staff spray and leave wet for 10 minutes and then dry with a rag. He/she also confirmed staff did not use the VIRASEPT to clean the floor surfaces, but used their regular disinfectant. He/she confirmed the disinfectant used did not kill C-difficile spores but they had talked about using it on the floors as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

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F 441	Continued From page 49	F 441		

During an interview on 6-6-2012 at 12:41 PM, Administrative Nurse I reported when a resident had diarrhea symptoms, he/she expected staff to provide care as if the resident had C-difficile until cultures were obtained. The staff used contact precautions, wore gowns, gloves, and masks. Depending on if the diarrhea was explosive, staff wore shoe covers. He/she reported there had been times in the past, if the resident had a carpeted room, staff moved the resident to a noncarpeted room for easier cleaning. A carpet cleaning crew come and clean the carpeted room.

The facility failed to plan and implement cleaning measures that killed clostridium difficile spores to prevent the spread of infection placing other residents and staff at risk to develop infection.

- Observation on 6-5-2012 at 3:19 PM, revealed direct care staff S and direct care staff ZZ assisted resident #13 out of bed and into the wheelchair. Observation revealed during the transfer, catheter bag laid on the floor beside the bed. When staff were ready to use the mechanical lift for the transfer, direct care staff S picked up the catheter and put it on the residents lap. The direct care staff then proceeded to raise the resident, using the mechanical lift, and the catheter bag remained on the resident's lap, at a level higher than the resident ' s bladder during the transfer. When the resident sat in the wheelchair staff ZZ then took the catheter and hung it on the side of the wheelchair. Without removing his/her gloves, staff ZZ gathered the soiled trash, walked out of the room, touched the door knob of the resident ' s room, and touched

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 50	F 441		

the door knob of the soiled utility room with dirty gloves on. Staff ZZ returned to the resident's room, removed his/her dirty gloves, and washed his/her hands.

During an interview on 6-12-2012 at 10:00 AM, Administrative Nurse I reported the staff were to use standard precautions in wearing gloves, the catheter bag and tubing were not to be on the floor and if the staff found a bag or tubing on the floor they are to report it to the charge nurse so that it can be changed. He/she also reported, even with back flow valves on the catheters, staff still needed to keep the bag below the level of the resident ' s bladder and keep it in a privacy cover.

Review of the policy for catheters and drainage bag care signed by Administrative Nurse I on 6-6-12 revealed the following steps needed to be followed by direct care staff. #1 - wash hands before and after providing catheter care -- #6 Do not allow the catheter bag holder, tubing or spigot to touch the floor - #8 Maintain a closed drainage system If the system must be opened, disinfect (e.g. with an alcohol wipe) the catheter tube junction before disconnection.

The facility failed to ensure the staff used appropriate hygienic practices for resident #13, who had a Foley catheter.

- Review of resident #41's medical record revealed the resident had a history of urinary tract infections with the last one dated 5/27/12.

On 6/6/12 at 7:30 AM, observation revealed Resident #41's foley catheter drainage bag,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 51 without the protective covering, dangled from the resident while he/she was in the hoyer lift. The bag was then allowed to rest on the floor while the staff adjusted the resident in his/her wheelchair. On 6/6/12 at 10:52 AM, observation revealed Resident #41's foley catheter drainage bag fell off the resident's leg during transfer in the hoyer lift and landed on the floor. The bag was allowed to lie on the floor and the resident's right foot was observed resting on the catheter bag. On 6/6/12 at 11:20 AM, Nurse assistant RR verified the catheter bags were to never touch the floor. On 6/6/12 at 4:10 PM, Nursing Staff JJ verified the staff were not to let the catheter bags rest on the floor. On 6/6/12 at 11:05 AM, observation revealed Nursing Assistant SS wore a red yarn bracelet on his/her left wrist while providing pericare/catheter care to resident #41. Observation further revealed the ends of the yarn bracelet were long and ran through the resident's pubic hair. Review of the facility's Urinary Catheter and Drainage Bag Care dated 10/1/09, revealed the staff were to not allow the catheter bag, holder, tubing, or spigot to touch the floor. The facility failed to provide appropriate hygienic and infection control practices for Resident #41.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 52	F 463		

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 123 residents. The sample included 24 residents. Based on observation and interview, the facility failed to ensure a working call system which functioned effectively and efficiently for 2 of the 24 sampled residents. (#1, #85)

Findings included:

- On 6/5/12 at 7:30 AM, observation revealed Resident # 1's call light was not functioning above his/her bed. When the staff attempted to activate the light, it had to be pulled out of the wall and plugged back in before it turned on. Staff could not turn off the call light and maintenance was called to fix the light.

On 6/5/12 at 7:40 AM, observation revealed Resident # 85's call light was not functioning in his/her bathroom or over his/her bed.

On 6/5/12 at 8:00 AM, Maintenance Staff KK verified the call lights were not functioning properly in the rooms of residents #1 and #85. He/She stated maintenance staff perform random checks weekly and checked at least one call light on each hall. Maintenance Staff KK verified uncertainty as to when the two call lights in question were checked last.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 53 The facility failed to ensure Resident #1 and Resident #85 had a functioning call light to enable them to call for staff assistance as needed.	F 463		